MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013753

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3274

FILED MAR 28 1963

DO NOT WRITE ON THIS STUB — AMENDED

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Rev. 4/59

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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MISSOURI
Length of stay in 1b: 2 m0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: BARNES HOSPITAL
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY: StLouis
c. CITY OR TOWN: Overland
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 1919 Bryant
Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First LAWRENCE Middle Last ROACH

4. DATE OF DEATH: Month MARCH Day 18 Year 1963

5. SEX: Male

6. COLOR OR RACE: White

7. Married [X] Never Married [ ] Widowed [ ] Divorced [ ]

8. DATE OF BIRTH: 7/25/1903

9. AGE (last birthday): 59
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HR: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Moulder

10b. KIND OF BUSINESS OR INDUSTRY: Brass

11. BIRTHPLACE (City and state or country): Belleville Ill

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: John Roach

13b. MOTHER'S MAIDEN NAME: Minnie Scheider

14. NAME OF HUSBAND OR WIFE: Aurelia Roach

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of servi

16. SOCIAL SECURITY NO.:

17. INFORMANT: Aurelia Roach Address: Overland Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA, TYPE UNDETERMINED
INTERVAL BETWEEN ONSET AND DEATH: 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 493XH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): CARCINOMA FLOOR OF MOUTH

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1/7/63 to 3/18/63 and last saw her him alive on 3/18/63
Death occurred at 11:20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C. E. Vermillion M.D. M.D.

22b. ADDRESS: BARNES HOSPITAL

22c. DATE SIGNED: 3/19/63

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 3/21/1963

23c. NAME OF CEMETERY OR CREMATORY: Green Mount

23d. LOCATION (City, town, or county) (State): Belleville Ill

24. FUNERAL DIRECTOR ADDRESS: Ortmann F Home 9222 Lackland Overland Mo

25. DATE RECD. BY LOCAL REG.: MAR 21 1963

26. REGISTRAR'S SIGNATURE: Hoard Smith. M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed A C Ortmann

Signature of Student Embalmer

Licensed Embalmer No. 3478

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.